UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ENBREL (enteracept)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

Diagnosis_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Diagnosis of severe Rheumatoid Arthritis, Ankylosing Spondylitis or Psoriatic Arthritis
- History of treatment, incomplete response or intolerance to Methotrexate, **AND** at least one other DMARD or second line drug (azathioprine, sulfasalazine, leflunomide, penicillamine, hydroxychloroquine, etc.)
- The number of swollen joints, must be 6 or more **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- The number of tender joints must be 9 or more. **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Rheumatology consultation within the last 60 days.
- May not be given with other biologic agents such as Interferon, experimental medications or combinations.

AUTHORIZATION:

Initial prior is for 12 weeks

RE-AUTHORIZATION:

Subsequent PA is for 12 months if the patient has at least 20% **DOCUMENTED** improvement in 4 of the following 6 areas: tender and swollen joint count, patient and or global assessment of disease activity, pain, acute phase reactants. Yearly letter updating response to Enbrel.